DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 04-007

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 07/01/04

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 :50

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 reflects decrease $75,588 ~~$0K~~
b. FFY 2005 reflects decrease 1,167,451 ~~$0K~~

8. CURRENT PAGES:
Attachment 4.19-B pages 4.1, 4.3, 4.4 .....

9. NEW PAGES:
Same

authorized via e mail from Russell Pederson Sent 4/25/05 P. Thompson 4/28/05

10. SUBJECT OF AMENDMENT:
Outpatient Hospital Rates

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT Robert Blanz ☐ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mark B. Moody

13. TYPED NAME:
Mark B. Moody

14. TITLE:
Administrator, Division of Health Care Financing

15. DATE SUBMITTED:
September 29, 2004

16. RETURN TO:
Mark B. Moody
Administrator, Division of Health Care Financing
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **9/30/04**

18. DATE APPROVED: 5/3/05

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A. Harris

21. TYPED NAME: **Cheryl A. Harris**

22. TITLE: **Associate Regional Administrator**
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
SEP 30 2004
DMCH - Milwaukee

FORM HCFA-179 (07-92)

4250 Budget Neutrality Factor. A budget neutrality factor is calculated for each upcoming State fiscal year. Whether or not a hospital is held-harmless depends on the budget neutrality factor that is applied in §4220 for calculating the rate per outpatient visit. Before calculating the budget neutrality factor, the Department identifies the amount of funds that are available in the upcoming State fiscal year to reimburse hospitals for outpatient services. The Department also estimates the gross projected costs to be incurred by each and all hospitals for these outpatient services. The budget neutrality factor is the quotient of the total funding available for reimbursing hospitals divided by the projected costs of all hospitals.

According to §4220, the budget neutrality factor times the average inflated costs per visit for each hospital results in eac hospital's rate per outpatient visit. A hospital gets its hold-harmless rate if its rate per outpatient visit is a lower rate The difference, that is, the extra funding needed to reimburse hold-harmless hospitals at their higher hold-har ıless rate, is taken-out of the funds available for paying the rate per outpatient visit.

Then, another calculation of the budget neutrality factor is done using the reduced available funding as the dividend and the projected hospital costs as the divisor. The resulting budget neutrality factor is applied to further decrease the rates per outpatient visit for all hospitals. Hold-harmless hospitals are again identified and available funds reduced for the extra funds needed for the hold-harmless hospitals.

This calculation of a budget neutrality factor is done over and over until there are no additional hold-harmless hospitals identified. At that time, this is the budget neutrality factor used for the calculating the rates per outpatient visit for the upcoming State fiscal year.

4300 Interim Payments.

Payments, based on an interim rate, are provided during a hospital's fiscal year. Interim payments are reconciled to reimbursable costs at the time of retroactive settlement. For most hospitals, this interim rate is the hospital's rate per outpatient visit or, if applicable, the hospital's hold-harmless rate. For new hospital providers for which an audited cost report is not available, the Department makes interim payments at the average percentage of allowed outpatient hospital charges paid to in-state hospitals. Clinical diagnostic laboratory tests performed with outpatient visits are paid at WMP fee schedule for such tests. The Department may adjust interim payment rates in order to approximate the amount that is expected to be due the provider upon final settlement. This may include, but is not limited to, administrative adjustments under §6000 and §6800.

4400 Computation of Retroactive Settlement

4410 Retroactive Settlement Period. A hospital's interim payments are reconciled to the hospital's reimbursable cost for the period of its audited cost report. Most cost reports cover the hospital's fiscal year but could cover a period other than twelve months. The period need not coincide with the State fiscal year.

4420 Allowable Outpatient Costs. A hospital's *"allowable outpatient costs"* are identified in its audited cost report and are determined according to applicable Medicaid and Medicare standards and principles of reimbursement (42 CFR Part 405 and HIM-15). The cost report provides a methodology of cost finding that identifies the amount of costs applicable to outpatient services provided persons eligible for fee-for-service coverage of the Wisconsin Medicaid program.

4900 Critical Access Hospitals

4920 Interim Payments. Interim payments are made at the critical access hospital's (CAH) average inflated cost per visit of §4210 above. The Department may adjust interim payment rates to approximate the retroactive settlement. A CAH may request the administrative adjustment under §6890, "Critical Access Hospital Interim Cost Payment Adjustment".

4930 Retroactive Settlement. Critical Access Hospital's outpatient payments are subject to a retroactive settlement based on the final Medicaid cost report for the hospital's fiscal year. The final settlement will compare the lower of the hospital's allowable costs, allowable charges, or "gross laboratory-fee-limited ceiling", with the interim Medicaid payments for those services.

A "gross laboratory-fee-limited ceiling" is the sum of the amounts calculated under items (a) and (b) below.

(a) For diagnostic laboratory tests provided in outpatient visits, the total amount that the WMP would reimburse for the laboratory tests based on the WMP fee schedule for such tests.

(b) For other services provided in the outpatient visits (that is, services other than the above laboratory tests), the lower of the following is determined, either (1) the total allowed charges for such other services, or (2) the total costs for such other services.

If the interim payments exceed the lower of the allowable costs, allowable charges, the department will recover the excess payments.

If the lower of the hospital's allowable cost, allowable charges exceed the interim payments, the department will reimburse the hospital by the amount of the lower of the hospital's allowable cost, allowable charges, minus interim payments.

5000 REIMBURSEMENT FOR OUTPATIENT SERVICES PROVIDED OUT-OF-STATE

Outpatient hospital services provided at all out-of-state hospitals, including border status hospitals, shall be paid at the average percentage of allowed outpatient hospital charges paid to in-state hospitals. Reimbursement for diagnostic laboratory services will be the lower of laboratory fee schedule amounts of the Wisconsin Medical Assistance Program or the hospital's laboratory charges for services rendered. Payment for outpatient services provided by out-of-state hospitals which are not certified as border status will be limited to emergency services or services prior authorized by the Wisconsin Medical Assistance Program.

5500 BORDER METROPOLITAN STATISTICAL AREA (MSA) SUPPLEMENT

552 Qualifying Criteria. A hospital may qualify for a border MSA supplement payment if it is located in a metropolitan statistical area (MSA) which has its primary urban area located in a state other than Wisconsin. MSA designations to be used are those used by CMS in the Medicare program on July 1, 1993.

5530 Calculation of Payment. A monthly payment will be determined for each qualifying hospital based on the amount of outpatient services which were provided to Wisconsin Medical Assistance Program (WMAP) recipients. Total annual supplemental payments to all qualifying hospitals shall not exceed an annual target amount. A monthly payment amount will be determined according to the following formula effective May 1994 through June 1995. As of July 1995 and each July thereafter, the payment amount will be updated and effective for each 12 month period, July through June.

V	=	Number of WMAP outpatient visits in the 12 month period which begins in the month of July, two calendar years prior to the effective date of the MSA supplement update. (Example, for the May 1, 1994 effective date, the 12 month period will be July 1992 through June 1993; for a July 1, 1995 effective date, July 1993 through June 1994 will be used.)
W	=	Weighting factor from table in §5540 below
V x W	=	Weighted visits of a qualifying hospital
Sum of (V x W)	=	Sum of weighted visits of all qualifying hospital
T	=	Statewide expenditure target amount as stated in §5560 below
M	=	Monthly payment to the qualifying hospital

Calculation: [(V x W) / Sum of (V x W) x T] / 12 months = M

5540 Weighting Factor. The weighting factor (W) will be selected from the following table based on the hospital's Medicaid utilization rate for services provided during its fiscal year which ended in the calendar year ending two years prior to the effective date of the supplemental payment. (Example, for May 1, 1994, the hospital's fiscal year ending in 1992 will be used; for a July 1, 1995 effective date, the hospital's fiscal year ending in 1993 will be used.) The hospital's Medicaid utilization rate will be the hospital's total charges for WMAP covered inpatient and outpatient services divided by the hospital's total charges for all patient services provided during its fiscal year. Total charges will be based on the charges reported by the hospital in its "Fiscal Year Hospital Fiscal Survey". Charges for WMAP services will be based on Medicaid claims submitted to the WMAP and will not include charges for services which were covered in full or part by Medicare and charges for services for which the WMAP did not make a payment to the hospital (such as hospital stays for which insurance paid the full amount for which the WMAP would have paid).

Medicaid Utilization Rate	Weighting Factor
Up through 7.5%	15
7.6% through 9.9%	30
10.0% and greater	45

5560 Target Amount. The annual target amount will be $250,000.